U.S. Department of Labor

Office of Administrative Law Judges
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DATE ISSUED: August 24, 2000

CASE NO.: 1999-BLA-349

In the Matter of

MERLIN HUEY GREENE,
Claimant

v.

CONSOLIDATION/ITMANN COAL COMPANY
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Bobby S. Belcher, Esquire
For the Claimant

Mary Rich Maloy, Esquire
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a duplicate claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.* ("Act"), filed on February 10, 1998. The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;

2. surviving dependents of coal miners whose death was due to pneumoconiosis ; and,

3. surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis, commonly called "black lung disease" or "coal workers pneumoconiosis" ("CWP"), as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

I. PROCEDURAL HISTORY

The claimant, Merlin Huey Greene, filed his initial claim for benefits on July 18, 1986. (DX 31)[1]. The claim was denied by the Department of Labor on December 1, 1986, because the evidence did not establish that Mr. Greene had pneumoconiosis caused at least in part by coal mine work or that he was totally disabled by the disease. Mr. Greene requested a hearing before the Office of Administrative Law Judges and the matter was referred to the OALJ on or about April 13, 1987, however the record reflects that no further action was taken in this matter and that the claim was eventually closed.

The present claim was filed on February 10, 1998. (DX 1). Itmann Coal Company was notified as the putative responsible operator on March 25, 1998. (DX 22). The Department of Labor, Office of Workers' Compensation Programs initially found Mr. Greene eligible for black lung benefits under the Act. (DX 24, 28). Because the employer contested this finding, interim benefits were commenced on behalf of Mr. Greene and his dependent wife, Sarah Greene, from the Black Lung Disability Trust Fund payable from February 1, 1998. (DX 29-30).

The employer appealed and the matter was forwarded to the Office of Administrative Law Judges on or about December 11, 1998. (DX 32). A hearing was initially scheduled for June 17, 1999, before Administrative Law Judge Gerald M. Tierney, however it was continued due to the claimant's health.

A hearing was held before Judge Tierney on November 30, 1999, at which time the claimant and his daughter, Merlina Dare Greene, presented without an attorney and with additional medical evidence regarding the claimant's condition. Based on this newly submitted evidence, Judge Tierney continued the hearing to allow the evidence to be submitted to the employer.

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[1] The following abbreviations are used herein for reference: DX-Director's Exhibit; CX-Claimant's Exhibit; EX-Employer's Exhibit; TR-Hearing Transcript

A hearing was held before the undersigned on June 16, 2000, in Charleston, West Virginia.[2] Both the claimant and employer were represented at the hearing, although Merlina Dare Greene did not show up for the hearing. No appearance was entered for the Director, Office of Workers' Compensation Programs. Counsel for the claimant stipulated to submit the case for a decision based on the evidence already in the record. (TR 6). Claimant's exhibits 1-3 and employer's exhibits 1-23 were admitted without objection. At the agreement of both parties, the claimant was given time post-hearing to submit documentation of Merlina Greene's appointment as the Administratrix of the claimant's estate and a certified copy of Mr. Greene's death certificate, which were submitted on July 10, 2000, and are now admitted as CX 4 and 5, respectively.

Additionally, counsel for the claimant forwarded numerous medical records of Mr. Greene's to this office on June 8, 2000, less than twenty days prior to the hearing in this matter. There is no indication that copies of the records were provided to the Employer; in fact, the records are not included in the Employer's comprehensive Pre-hearing Report. While several of the records contained in this packet were entered into evidence through other means, the entire group of records was never offered, and therefore never admitted, into the record of this case.

II. ISSUES

A. Whether there was a material change in claimant's condition?

B. Whether the miner had pneumoconiosis as defined by the Act and the Regulations?

C. Whether the miner's pneumoconiosis arose out of his coal mine employment?

D. Whether the miner was totally disabled?

E. Whether the miner's disability was due to pneumoconiosis?

III. FINDINGS OF FACT

A. Coal Miner

The records establish that the claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations, from 1942 through 1986. (DX 2, 3, 5). No evidence has been submitted to the contrary; as such, I find Mr. Greene was a coal miner for at least 44 years.

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[2] Under *Kopp v. Director, OWCP*, 877 F.2d 307, 309 (4th Cir. 1989), the area the miner was exposed to coal dust is determinative of the circuit court's jurisdiction.

B. Date of Filing

The claimant filed his claim for benefits, under the Act, on February 10, 1998. (DX 1). None of the Act's filing time limitations are applicable; thus, the claim was timely filed.

C. Responsible Operator

Mr. Greene was employed by Itmann Coal Company from 1949 through his retirement in 1986 and Itmann is therefore the properly designated responsible coal mine operator in this case, under Subpart F, Part 25 of the Regulations. (DX 5). It is noted that Itmann Coal Company does not contest this issue. (DX 32).

D. Dependents[3]

The claimant had one dependent for purposes of augmentation of benefits under the Act, his wife Sarah Cook, who passed away in March of 1999. (DX 9; TR p. 6).

E. Personal and Employment History

The claimant, decedent miner, was born on December 21, 1923. He married Sarah on June 22, 1946. (DX 9). He worked in the coal mines for at least 44 years. The record indicates that Mr. Greene passed away on February 5, 2000, and that his daughter, Merlina Dare Greene, was appointed the Executrix of his estate on February 14, 2000.

IV. MEDICAL EVIDENCE

The following is a summary of the medical evidence submitted in both his prior and most recent claims.

A. Chest x-rays

The radiographic evidence submitted in the record of this matter is contained in Appendix A, which is attached hereto.

In summary, there were 46 interpretations of 12 chest x-rays submitted in the record of Mr. Greene's present claim. In addition, two interpretations of two x-ray films were submitted in connection with Mr. Greene's initial claim for benefits.

Of the total interpretations submitted, five were interpreted as positive for simple pneumoconiosis (DX 18, 20, 21, 31 and CX 2) and one was interpreted as positive for complicated

[3] See 20 C.F.R. §§ 725.204-725.211.

pneumoconiosis (CX 1). Three films were interpreted as 0/1, which is not evidence of pneumoconiosis. (DX 16, 19, 31). The remaining films were interpreted as showing no evidence of changes consistent with pneumoconiosis.

B. CT Scans [4]

CT scans of Mr. Greene's chest were performed on September 13, 1999, and December 9, 1999, and were interpreted by several physicians.

Paul S. Wheeler, M.D., a Board-certified radiologist interpreted the September 13, 1999 scan. (EX 12). According to his interpretation, the CT scan showed cardiomegaly with minimal arteriosclerosis left coronary and moderate calcification aortic valve. There was a small right pleural effusion and probable discoid atelactasis in right upper and lower chest. He noted aneurysmal dilatation aortic arch and upper descending thoracic aorta to 4.5 cm diameter. Dr. Wheeler also noted moderate obesity with extensive intra-abdominal and mediastinal fat deposits and arteriosclerosis abdominal aorta and iliacs. There was no evidence of silicosis or coal workers' pneumoconiosis.

Dr. William W. Scott, a Board-certified radiologist, also interpreted the same CT scan. (EX 13). He noted the presence of a 3 centimeter mass in the right upper lobe with peripheral calcification, probably related to treated lung cancer, although he could not rule out a neoplasm. He also noted a 3 centimeter mass in the superior segment right lower lobe. There was a small right pleural effusion and subpleural fat on the right chest wall. Aortic valve calcification may indicate aortic stenosis. There was dilatation of aortic arch to 4 centimeters diameter. Mr. Greene's kidneys were atrophic and there was a 2 centimeter low-attenuation lesion in the spleen. Dr. Scott concluded that there was no evidence of silicosis or CWP.

Dr. Jerome F. Wiot, a Board-certified radiologist, also interpreted the September 13, 1999, CT scan and found no evidence of coal workers' pneumoconiosis. (EX 18). He noted a mass in the right upper lung field and changes throughout the right lung consistent with post-radiation changes or inflammatory disease which were not manifestations of coal dust exposure. There was also right pleural effusion and mediastinal adenopathy in the pretracheal area. Within the superior segment of the lower lobe, Dr. Wiot noted a mass-like density containing an air bronchogram which was inflammatory in nature.

The December 9, 1999 scan was interpreted by Wiot. (EX 17). He found no evidence of coal workers' pneumoconiosis, but revealed a prominent right pleural effusion. There were changes throughout the entire right lung field consistent with post-radiation changes, as well as mediastinal adenopathy. There was a strong suggestion of two metastatic lesions within the liver.

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[4] A CAT scan falls into the "other means" category of 20 C.F.R. § 718.304(c) rather than being considered an x-ray under § 718.304(a). A CAT Scan is "computed tomography scan or computer aided tomography scan. Computed tomography involves the recording of 'slices' of the body with an x-ray scanner (CT scanner). These records are then integrated by computer to give a cross-sectional image. *See Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991).

Dr. Christopher A. Meyer, a Board-certified radiologist, also interpreted the December 9, 1999, CT scan, and concluded there was no evidence of coal workers' pneumoconiosis. Rather,

the findings were compatible with Stage IV lung cancer. (EX 18). He also noted extensive coronary artery calcification as well as calcification at the aortic root.

The December 9, 1999, CT scan was interpreted by Dr. Harold B. Spitz, a Board-certified radiologist. (EX 20). He noted an extensive infiltrate in the lung with more localized anterior and posterior opacities. There was mediastinal lymph node enlargement, right pleural effusion and several low-density lesions within the liver. There was no evidence of CWP.

C. Pulmonary Function Studies

Pulmonary Function Tests (PFS) are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

Physician Date Exh.#	**Age Height**	**FEV_1**	**MVV**	**FVC**	**Compre-hension Cooper-ation**	**Qualify* Conform ****	**Impression**
Daniel 9/8/86 **DX 31**	62 72.5	3.35	133	4.25	Good Good	No* Yes**	Normal
Rasmussen 4/17/98 **DX 10**	74 71"	2.79	107	3.89	Good Good	No* Yes**	Normal.
Castle 1/13/99 **EX 2**	75 70"	2.34 2.42+	86 91+	3.23 3.40+	Good Good	No* No*+	No obstruction, no restriction. Diffusion entirely normal.

* A "**qualifying"** pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

** A study "**conforms**" if it complies with applicable quality standards (found in 20 C.F.R. § 718.103(b) and (c)). *See Old Ben Coal Co. v. Battram*, 7 F.3d. 1273, 1276 (7th Cir. 1993). A judge may infer, in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP*, 6 B.L.R. 1-83 (1984).

+Post-bronchodilator.

For a miner of the height of 71" inches, § 718.204(c)(1) requires an FEV_1 equal to or less than 1.94 for a male 71 years of age. If such an FEV_1 is shown, there must be in addition, an FVC equal to or less than 2.51 or an MVV equal to or less than 78; or a ratio equal to or less than 55% when the

results of the FEV1 test are divided by the results of the FVC test.[5] Qualifying values for other ages and heights are as depicted in the table below. The FEV_1/FVC ratio requirement remains constant.

Height	Age	FEV_1	FVC	MVV
72.5"	62	2.21	2.82	89
71	74	1.94	2.51	78
70	75	1.88	2.43	75

D. Arterial Blood Gas Studies[6]

Blood gas studies are performed to detect an impairment in the process of aveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide in the blood indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

Date Ex.#	Physician	pCO_2	pO_2	Qualify	Physician Impression
9/8/86 **DX 31**	Daniel	38 37+	70 78+	No No+	
4/17/98 **DX 10**	Rasmussen	40 39+	66 57+	No Yes+	Minimal resting hypoxia.
1/13/99 **EX 2**	Castle	42.5 40.9+	62 61+	No No+	ABG's at the lower limits of normal

+ Results, if any, after exercise.

E. Physicians' Reports

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from

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[5] The fact-finder must resolve conflicting heights of the miner on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the test are "qualifying." *Toler v. Eastern Associated Coal Co.*, 43 F.3d 3 (4th Cir. 1995). I find the miner is 71" here, the average reported height.

[6] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.
20 C.F.R. § 718.204(c) permits the use of such studies to establish "total disability." It provides:
In the absence of contrary probative evidence, evidence which meets the standards of either paragraphs (c)(1), (2), (3), (4), or (5) of this section shall establish a miner's total disability: . . .
(2) Arterial blood gas tests show the values listed in Appendix C to this part . . .

pneumoconiosis. 20 C.F.R. § 718.202(a)(4). Where total disability cannot be established, under 20 C.F.R § 718.204(c)(1), (2), or (3), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b).

Mr. Greene was examined by John M. Daniel, M.D., in connection with his first claim for benefits on September 8, 1986. (DX 31). Dr. Daniel noted that Mr. Greene smoked ½ pack of cigarettes for 15 years, but quit smoking in 1966. He also noted that Mr. Greene worked in coal mine employment for 42 years, 3.5 inside the mines and 38.5 outside the mines as a heavy equipment mechanic. Dr. Daniel diagnosed Mr. Greene with pneumoconiosis related to his coal mine employment, based on x-ray evidence. He concluded, however, that there was no evidence of significant pulmonary dysfunction and that Mr. Greene should be able to perform his usual coal mine activities.

The employer submitted an additional report from Dr. Daniel, dated November 2, 1999, after Dr. Daniel's review of Mr. Greene's additional medical records. (EX 14). Dr. Daniel also submitted a curriculum vitae noting that he is Board-certified in family practice. Dr. Daniel's review of the chest x-rays lead him to conclude that there was "probably not" sufficient evidence of pneumoconiosis and, even though several x-rays were interpreted 0/1 or 1/0, there "appears to be no real x-ray evidence of pneumoconiosis." He found no evidence of pulmonary or respiratory impairment until approximately April of 1998, however he found that this impairment was due to excess obesity, multiple pulmonary emboli, cardiac problems and Mr. Greene's age; the impairment was not related in any way to pneumoconiosis or exposure to coal dust. Dr Daniel did opine that Mr. Greene was totally and permanently disabled due to lung cancer, extreme obesity and his age, in addition to his development of auricular fibrillation in August of 1999. He concluded that pneumoconiosis was not a factor in contributing to any form of respiratory impairment.

Mr. Greene was examined by Dr. D. L. Rasmussen, Board-certified in internal medicine, on April 17, 1998.[7] (DX 11-12). Dr. Rasmussen noted that Mr. Greene was employed in the coal mines from 1939 through 1986, in various capacities. He also noted a smoking history of an average of one pack of cigarettes per day for 28 years, quitting in 1970. Mr. Greene presented with complaints of progressive shortness of breath on exertion for 10 to 15 years, a chronic productive cough, intermittent wheezing, and chest pain and discomfort.

Based on a history, physical examination, a chest x-ray interpreted by Dr. Patel, a B-reader and Board-certified radiologist, electrocardiogram, ventilatory function studies, arterial blood gas studies and incremental treadmill exercise study, Dr. Rasmussen diagnosed Mr. Greene with coal

[7] I take judicial noted of Dr. Rasmussen's credentials from the American Board of Medical Specialties certified doctor verification service.

workers' pneumoconiosis arising from his coal mine employment. He also concluded that Mr. Greene had at least a moderate loss of respiratory function, reflected principally by the impairment in oxygen transfer during exercise. This degree of impairment would render the claimant totally disabled for resuming his last regular coal mine job, due to its attendant requirement for some heavy manual labor. The risk factors for Mr. Greene's respiratory insufficiency included cigarette smoking, coal mine dust exposure and possibly his pulmonary embolization, however, Dr. Rasmussen concluded that coal mine dust exposure was a significant contributing factor.

Mr. Greene was examined by James R. Castle, M.D., who is a B-reader and Board-certified in internal medicine with a sub-specialty in pulmonary diseases, on April 14, 1999. (EX 2). Dr. Castle also reviewed numerous past medical records. Mr. Greene reported to him that he smoked between 1.5 and one pack of cigarettes per day from the time he was 22 years old until 28 years prior to the examination, for a total of 13-26 pack years. He also noted 43 years of coal mine employment and that Mr. Greene retired due to his back. Based on review of the medical records, physical examination, chest x-ray, normal pulmonary function studies, arterial blood gas studies, and electrocardiogram, Dr. Castle concluded that Mr. Greene did not suffer from coal workers' pneumoconiosis. He did not find any changes of pneumoconiosis on chest x-rays; however, a mass in the hilum was seen and reported to the claimant. In addition, he found other risk factors, namely tobacco abuse and obesity, for the development of his pulmonary symptoms.
Dr. Castle also performed pulmonary function studies, which he found were valid and normal.

Dr. Castle concluded that Mr. Greene did not have the physical, radiologic, physiologic or arterial blood gas findings to indicate the presence of coal worker's pneumoconiosis. In addition, he opined that Mr. Greene retained the respiratory capacity to perform his usual coal mining employment duties. While he did find Mr. Greene to be totally disabled from a whole man standpoint, he determined that the total disability was due to obesity, obstructive sleep apnea syndrome, hypertension, probably coronary artery disease, previous pulmonary emboli, and age, none of which was related to his coal mine employment. Even presuming the existence of coal worker's pneumoconiosis radiographically, Dr. Castle opined that he was not disabled as a result of the disease.

Dr. Castle was deposed regarding his findings on June 8, 1999. (EX 8). Dr. Castle testified in detail regarding his qualifications, as well as his findings from Mr. Greene's physical examination. In addition to reiterating the substance of his report, Dr. Castle discussed sleep apnea and pulmonary emboli, two conditions which he found in Mr. Greene that were unrelated to his coal mine employment and more likely related to his obesity. Dr. Castle disagreed with Dr. Rasmussen's findings of April 17, 1998 that Mr. Greene had a moderate loss of lung function because they were based on a fall in his PO2 levels after exercise. Dr. Castle opined that the fall was caused either by morbid obesity, pulmonary emboli, or coronary artery disease. His conclusions remained the same as those stated in his report.

On April 18, 2000, Dr. Castle reviewed the most recent medical records and again concluded that there were no chest x-ray changes indicating the presence of coal workers' pneumoconiosis. (EX 21). His conclusion remained that there was no CWP and no evidence of respiratory impairment or

disability.

Thomas M. Jarboe, M.D., who is a B-reader and a Board-certified internist with a sub-specialty in pulmonary diseases, submitted a report dated May 11, 1999, after a review of Mr. Greene's medical records. (EX 5). After review of the records, Dr. Jarboe concluded there was insufficient objective evidence to justify a diagnosis of coal worker's pneumoconiosis. In making such a determination, Dr. Jarboe noted the majority of highly qualified doctors interpreted the chest x-rays as negative, that pulmonary function tests were persistently normal

with no restriction or obstruction, that his total lung capacity and diffusion capacity were normal, and that there was no reduction of FVC or FEV1 as there would be if he had an impairment due to coal dust inhalation.

Dr. Jarboe also concluded that the totality of the data provided to him indicated that Mr. Greene did not have a significant respiratory impairment, again noting normal spirometry, lung volumes and diffusion capacity. He concluded that Mr. Greene was not totally disabled from a respiratory standpoint, rather he was disabled as a whole man due to obesity, hypertension, and possible coronary disease. Each of these conditions was unrelated to his coal mine employment.

Dr. Jarboe reviewed the x-ray interpretations of Drs. Aycoth and Cappiello, but disagreed with their findings, concluding again that there was not radiographic evidence supporting a diagnosis of pneumoconiosis. (EX 21). His conclusions remained the same regarding the lack of pulmonary impairment and disability.

A review of the medical records was also conducted by George L. Zaldivar, M.D., who is a B-reader and Board-certified internist with sub-specialties in pulmonary disease, sleep disorders and critical care medicine. (EX 6). Dr. Zaldivar submitted a report summarizing his conclusions dated May 12, 1999. His review lead him to conclude that Mr. Greene did not have coal workers' pneumoconiosis, nor did he have any pulmonary impairment. While there was no evidence of any total or permanent disability, potentially Mr. Greene could be disabled due to his numerous other physical problems, including obesity and possible coronary artery disease. Even assuming Mr. Greene did have pneumoconiosis, Dr. Zaldivar's opinions concerning his disability would not change.

Dr. Zaldivar submitted a supplemental report, dated April 5, 2000, after review of the positive x-ray interpretations by Drs. Aycoth and Cappiello. (EX 19). Neither of these reports changed his original opinions. Rather, he opined that these films indicated that Mr. Greene had developed cancer in the right lung. He opined that the findings could not be complicated pneumoconiosis, since it was not present as recently as 1998.

Dr. Gregory J. Fino, who is a B-reader and Board-certified in internal medicine with a sub-specialty in pulmonary diseases, reviewed Mr. Greene's medical records and submitted a report dated November 4, 1999. (EX 15). He concluded that Mr. Greene did not suffer from an occupationally acquired pulmonary condition as a result of coal mine dust exposure based on the majority of negative

x-rays including his own reading, normal spirometric evaluations with no obstruction, restriction or ventilatory impairment, and normal diffusing capacities which rules out clinically significant pulmonary fibrosis such as pneumoconiosis. He noted that Mr. Greene's elevated lung volumes was consistent with obstructive lung disease typical in patients with emphysema, asthma or chronic bronchitis, but not consistent with the contraction of lung tissue due to fibrosis as would be expected in simple CWP. Dr. Fino also concluded that there was no evidence of a ventilatory impairment. He attributed Mr. Greene's blood gas abnormality to obesity, obstructive sleep apnea and a history of pulmonary emboli. From a respiratory standpoint, Mr. Greene was not totally disabled from performing his last mining job.

Dr. Fino submitted a supplemental report, dated April 15, 2000, after review of additional medical records, namely two x-ray interpretations which were positive for pneumoconiosis. (EX 21). He opined that this evidence did not cause him to change his opinions and that his own review of the films did not evidence pneumoconiosis. He stressed that he certainly did not agree with Dr. Aycoth's diagnosis of complicated pneumoconiosis.

The deposition of Dr. Fino was taken on May 18, 2000. (EX 23). He testified that there is no causal relationship between lung cancer and exposure to coal mine dust or to the development of coal workers' pneumoconiosis. (EX 23, p. 10). Rather, he believed that cigarette smoking was the cause of Mr. Greene's lung cancer. (EX 23, p. 26). He also testified that pneumoconiosis in not a condition which causes intermittent abnormalities; rather, it is a permanent condition. (EX 23, p. 14). He reiterated that Mr. Greene's pulmonary capacity was normal and that there had been no change in his ventilatory capacity over the years.

F. Hospital Records

The Employer submitted medical records from ARH Medical Associates from July 28, 1999 through September 23, 1999, where Mr. Greene was apparently treated for small cell carcinoma of the lung. (EX 10). During this time, he was treated by Dr. Mayez el-Harake. One hospital note, dated September 23, 1999, notes that Mr. Greene had COPD. However, there are no other references in the hospital records with regard to his coal mine employment or its relation to any of his physical conditions.

G. Other

Mr. Greene was awarded partial disability benefits in West Virginia on or about January 17, 1985, based on a finding by the West Virginia Occupational Pneumoconiosis Board that he had occupational pneumoconiosis with no more than a 15 % pulmonary functional impairment attributable to the disease. (DX 4).

Mr. Greene passed away on February 5, 2000. His death certificate, completed by Dr. Mayez El-Harake, listed lung cancer as the immediate cause of death. (CX 5).

V. CONCLUSIONS OF LAW

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, and that he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. *20 C.F.R. §§ 718.202-718.205; Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986).

B. Material Change in Conditions

Since the present claim was filed more than one year after the denial of his previous claim, the claimant must initially show there has been a material change in his condition.[8] The duplicate claims regulation, 20 C.F.R. § 725.309(d), directs that new claims shall be denied based on the earlier denial absent a threshold showing of a material change in the claimant's conditions.

The Fourth Circuit follows the so-called "one-element" standard for determining if a material change in conditions has occurred, which requires the claimant to prove, under all of the probative medical evidence of his condition *after* the prior denial, both favorable and unfavorable, at least one of the elements previously adjudicated against him. *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358, 1362 (4th Cir. 1996). *See also Labelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995); *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994).

The Fourth Circuit does not require consideration of the evidence in the prior claim to determine whether it "differ[s] qualitatively" from the new evidence. *Lisa Lee*, 86 F.3d at 1363 n. 11. The Administrative Law Judge ("ALJ") must simply determine whether the new evidence, in and of itself, establishes any one of the elements previously adjudicated against the miner in a previous claim. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. The ALJ must then consider whether all of the record evidence, including that submitted with the previous claim, supports a finding of entitlement to benefits.

The claimant's first application for benefits was denied in a Department of Labor form letter, with sections checked indicating that the claimant had failed to show: (1) he had pneumoconiosis; (2) the pneumoconiosis arose, at least in part, out of coal mine employment; and (3) the claimant was totally disabled due to pneumoconiosis. (DX 31). Therefore, the Director found the claimant had not established any of the elements of entitlement.

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[8] Section 725.309(d) provides, in pertinent part:

> In the case of a claimant who files more than one claim for benefits under this part, . . . [i]f the earlier miner's claim has been finally denied, the later claim shall also be denied, on the grounds of the prior denial, unless the [Director] determines there has been a material change in conditions . . . (Emphasis added).

Based on the evidence submitted since the denial of the claimant's previous claim, I find that the evidence establishes that Mr. Greene was totally disabled from performing his last coal mine employment or any comparable, gainful employment, prior to his death. Each physician who examined Mr. Greene, or reviewed his medical records, concluded that Mr. Greene was totally disabled from a "whole man" standpoint. As such, he has met this element of entitlement, as discussed further below.

As the claimant has established proof of one of the elements previously adjudicated against him, he has therefore established a material change in conditions which now warrants a review of all the evidence of record, including that from the previous claim, to determine whether he is entitled to benefits.

C. Existence of Pneumoconiosis

30 U.S.C. § 902(b) and 20 C.F.R. § 718.201 define pneumoconiosis as a "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. §718.201. The term "arising out of coal mine employment" is defined as "significantly related to, or substantially aggravated by, dust exposure in coal mine employment."

"...[T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) citing, *Rose v. Clinchfield Coal Co.*, 614 F. 2d 936, 938 (4th Cir. 1980). Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995).

The claimant has the initial burden of proving that he suffers from coal workers' pneumoconiosis arising out of coal mine employment. 20 C.F.R. § 718.202, 718.203, 718.204. He may establish the existence of pneumoconiosis by any one of four methods: (1) a chest x-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion. 20 C.F.R. § 718.202(a).[9]

[9] There is no biopsy or autopsy evidence in this matter; as such, this section is inapplicable.

The Fourth Circuit recently held that, in making a determination as to the existence of pneumoconiosis, an administrative law judge must weigh all the evidence together under 20 C.F.R. § 718.202(a) to determine whether a miner suffers from the disease. *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000). In doing so, the court reasoned:

> Weighing all of the relevant evidence together makes common sense. Otherwise, the existence of pneumoconiosis could be found even though the evidence as a whole clearly weighed against such a finding. For example, suppose x-ray evidence indicated that the miner has pneumoconiosis, but autopsy evidence established that the miner did not have any sort of lung disease caused by coal dust exposure. In such a situation, if each type of evidence were evaluated only within a particular subsection of § 718.202(a) to which it related, the x-ray evidence could support an award for benefits in spite of the fact that more probative evidence established that benefits were not due.

Compton, Slip. op. at 4. As such, the evidence of record under each of the subsections of § 718.202(a) will be considered together in making a determination as to the existence of pneumoconiosis.

A finding of the existence of pneumoconiosis may be made with positive chest x-ray evidence. 20 C.F.R. § 718.202(a)(1). "[W]here two or more x-ray reports are in conflict, in evaluating such x-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such x-rays." *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985) (Fact one is Board-certified in internal medicine or highly published is not so equated); *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991) at 1-37. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n. 5 (1985).

Pneumoconiosis is a progressive and irreversible disease such that it is proper to accord greater weight to later positive x-ray studies over earlier negative ones. Generally, "later evidence is more likely to show the miner's current condition" where it is consistent in demonstrating a worsening of the miner's condition. *Lane Hollow Coal Co. v. Director, OWCP [Lockhart]*, 21 B.L.R. 2-302, 137 F.3d 799, (4th Cir., Mar. 3, 1998). It is rational to credit more recent evidence, solely on the basis of recency, only if it shows the miner's condition has progressed or worsened. The court reasoned that, because it is impossible to reconcile conflicting evidence based on its chronological order if the evidence shows that a miner's condition has improved, in as much as pneumoconiosis is a progressive disease and claimants cannot get better, "[e]ither the earlier or the later result must be wrong, and it is just as likely that the later evidence is faulty as the earlier. . ." *Adkins v. Director, OWCP*, 958 F.2d 49, 16 B.L.R. 2-61 (4th Cir. 1992). *See also, Thorn v. Itmann Coal Co.*, 3 F.3d 713, 18 B.L.R. 2-16 (4th Cir. 1993).

There were a total of 48 interpretations of 14 x-ray films submitted in this matter, ranging in date from 1986 through 2000. (Appendix A). Of these, five were interpreted as positive for simple pneumoconiosis (DX 18, 20, 21, 31 and CX 2) and one was interpreted as positive for complicated pneumoconiosis (CX 1). Three films were interpreted as 0/1, which is not evidence of pneumoconiosis. (DX 16, 19, 31). The remaining films were interpreted as showing no evidence of changes consistent with pneumoconiosis.

Dr. Daniel, who is Board-certified in family medicine, interpreted a September 8, 1986 film as positive for pneumoconiosis. (DX 31). However, in a subsequent report dated November 2, 1999, after review of additional x-ray films, Dr. Daniel concluded that there was "probably not" sufficient evidence to diagnose pneumoconiosis via x-ray. Furthermore, as Dr. Daniel is not a radiologist or B-reader, his interpretation is given lesser weight. *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985).

The remaining interpretations which were positive for simple pneumoconiosis were by Dr. Patel, a B-reader and Board-certified radiologist, Dr. Gaziano, a B-reader, and Dr. Aycoth, a B-reader and Board-certified radiologist. Each of these films was subsequently interpreted as negative by at least two dually-qualified physicians.

In addition, the seven most recent x-ray films, from March 9, 1999 through January 17, 2000, were interpreted as negative for pneumoconiosis by all of the reviewing physicians.

While a judge is not required to defer to the numerical superiority of x-ray evidence, although it is within his or her discretion to do so. *Wilt v. Woverine Mining Co.*, 14 B.L.R. 1-70 (1990) citing *Edmiston v. F & R Coal*, 14 B.L.R. 1-65 (1990). The ALJ must rely on the evidence which he deems to be most probative, even where it is contrary to the numerical majority. *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1984).

Given the majority of readings from the most recent x-ray films by the most qualified physicians are negative for the existence of pneumoconiosis, I find that the x-ray evidence, in and of itself, is not sufficient to establish the existence of pneumoconiosis.

I also note that two CT scans dated September 13, 1999 and December 13, 1999 were negative for CWP. On the September 13, 1999 CT scan, Drs. Wheeler, Scott and Wiot, all Board-certified radiologists, did not find evidence of CWP or silicosis and noted evidence of lung cancer. Interpreting the December 9, 1999 CT scan, Drs. Wiot, Meyer and Spitz, Board-certified radiologists, found no evidence of CWP and Dr. Meyer noted Stage IV lung cancer.

A claimant may also establish the existence of pneumoconiosis pursuant to the so-called "irrebuttable presumption" set forth in 20 C.F.R. § 718.304. Under § 718.304, there is an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis, if such a miner is suffering from complicated pneumoconiosis. Complicated pneumoconiosis is established by x-rays classified as Category A, B, or C, or by an autopsy or biopsy which yields massive lesions in the lung. The determination of whether the miner has complicated pneumoconiosis is a finding of fact, and the

Judge must consider and weigh all relevant evidence. *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991); *Maypray v. Island Creek Coal Co.*, 7 B.L.R. 1-683 (1985).

The only evidence of record that suggests Mr. Greene had complicated pneumoconiosis was the February 29, 1999 reading of an x-ray taken January 13, 1999, by Dr. Aycoth. (CX 1). Dr. Aycoth interpreted the film as showing complicated pneumoconiosis, category A, p/p. However, the same film was interpreted by four other physicians, none of whom found complicated pneumoconiosis. Even Dr. Cappiello, who read the film as positive for pneumoconiosis, noted that there were no large lesions of complicated pneumoconiosis. Furthermore, there were 22 readings of seven x-ray films of Mr. Greene's chest taken subsequent to January 13, 1999, none of which were interpreted by any physician as showing complicated pneumoconiosis. I find the sole interpretation by Dr. Aycoth insufficient to establish the existence of complicated pneumoconiosis.

Finally, a determination of the existence of pneumoconiosis can also be made if a physician, exercising sound medical judgment, based upon certain clinical data and medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative x-ray. 20 C.F.R. § 718.202(a). As with the x-ray evidence, more weight is generally given to the most recent evidence because pneumoconiosis is a progressive and irreversible disease. *Stanford v. Director, OWCP*, 7 B.L.R. 1-541 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-166 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984).

Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an ALJ may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contraindicates it. *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

The only physician of record who concluded that Mr. Greene suffered from pneumoconiosis was Dr. Rasmussen, who examined the claimant on April 17, 1998. (DX 11-12). Dr. Daniel, who originally diagnosed CWP in September of 1986, later changed his opinion. In November of 1999, Dr. Daniel found that there was "probably not" sufficient evidence to diagnose pneumoconiosis. Drs. Fino, Jarboe, Castle and Zaldivar, all Board-certified in internal medicine with a sub-specialty in pulmonary diseases, as well as a B-readers, found no evidence to support a diagnosis of CWP.

In assessing the probative value to which Dr. Rasmussen's opinion is entitled, it is proper to consider his qualifications. Dr. Rasmussen, Board-certified in internal medicine, is less qualified than the other physicians of record who did not diagnose CWP. As such, I give lesser weight to Dr. Rasmussen's conclusions, than to those of Dr. Castle, who also examined the claimant, Dr. Fino, Dr. Jarboe and Dr. Zaldivar. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984).

Considering the well reasoned opinions of pulmonary specialists, Drs. Fino, Castle, Jarboe and Zaldivar, in conjunction with my finding that the x-ray evidence does not establish CWP and the negative CT readings, the claimant has failed to meet his burden on this element of entitlement. After consideration of the evidence under each subsection of Section 718.202(a), as well as all of the medical evidence together, I find that the evidence submitted is insufficient to establish the existence of pneumoconiosis in this matter.

D. Cause of pneumoconiosis

Once the miner is found to have pneumoconiosis, the claimant must show it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

Since Mr. Greene had more than ten years of coal mine employment, the claimant would ordinarily receive the benefit of the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. However, in view of my finding that the existence of pneumoconiosis has not been proven this issue is moot.

E. Existence of total disability

The claimant must show he is totally disabled from performing his most recent coal mine work or some other gainful employment requiring similar skills. 20 C.F.R. § 718.204(b). Sections 718.204(c)(1) through (c)(5) set forth criteria for establishing total disability:
(1) pulmonary function studies with qualifying values; (2) blood gas studies with qualifying values; (3) evidence the miner has pneumoconiosis and suffers from cor pulmonale with right-sided congestive heart failure; (4) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment; and
(5) lay testimony. Under this subsection, the ALJ must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, the ALJ must assign the evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986, aff'd on reconsideration en banc, 9 B.L.R. 1-236 (1987).

Section 718.204(c)(3) is not applicable because there is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure. § 718.204(c)(5) is not applicable because it only applies to a survivor's claim in the absence of medical evidence.

I note that the pulmonary function test results submitted in this case were all non-qualifying. In addition, except for the post-exercise arterial blood gas results of April 17, 1998, all of the arterial blood gas studies submitted were also non-qualifying. As such, these values are not sufficient, in and of

themselves, to establish total disability pursuant to § 718.204(c)(1) or (c)(2).

With respect to the April 17, 1998, post-exercise results, Dr. Castle noted that there was no change at peak exercise when he performed arterial blood gas tests on April 14, 1999. (EX 2). Dr. Fino explained that if coal workers' pneumoconiosis was present, the drop in pO2 post-exercise would have been seen on Dr. Castle's testing, as well as Dr. Rasmussen's, noting that the latter test was within normal limits. (EX 15). He explained that pneumoconiosis does not cause intermittent abnormalities; rather it is a permanent condition. (EX 23, p. 14).

Finally, total disability may be demonstrated, under § 718.204(c)(1), if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b). Under this subsection, " . . . all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element." *Mazgaj v. Valley Camp Coal Company*, 9 B.L.R. 1-201 (1986) at 1-204. The fact finder must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work a *prima facie* finding of total disability is made and the burden of going forward with evidence to prove the claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined pursuant to 20 C.F.R. § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

Each physician who examined Mr. Greene or reviewed his medical records conceded that this man was totally disabled from a "whole man" standpoint prior to his death, although causation of such total disability was not conceded. The issues of total disability and causation are independent determinations with respect to a claim for black lung benefits. *Billings v. Harlan #4 Coal Co.*, BRB No. 94-3721 BLA (June 19, 1997) (unpublished). I find that the evidence does establish that Mr. Greene was totally disabled prior to his death and, as such, has established this element of entitlement.

F. Cause of total disability

The Board requires that pneumoconiosis be a "contributing cause" of the miner's disability. *Scott v. Mason Coal Co.*, 14 B.L.R. 1-37 (1990)(*en banc), overruling Wilburn v. Director, OWCP*, 11 B.L.R. 1-135 (1988). Likewise, the Fourth Circuit Court of Appeals, under whose jurisdiction this matter arises, requires that pneumoconiosis be a "contributing cause" to claimant's total disability. *Toler v. Eastern Associated Coal Co.*, 43 F. 3d 109, 112 (4th Cir. 1995); *Jewel Smokeless Coal Corp. v. Street,* 42 F.3d 241, 243 (4th Cir. 1994). In *Street*, the Court emphasized the steps by which the cause of total disability may be determined by directing "the Administrative Law Judge [to] determine whether [the claimant] suffers from a respiratory or pulmonary impairment that is totally disabling and whether [the claimant's] pneumoconiosis contributes to this disability." *Street,* 42 F.3d 241 at 245. The claimant need not prove that pneumoconiosis is the "sole" or "direct" cause of his respiratory disability, but rather that it has contributed to his disability. *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP, 914 F.2d 35*, 14 B.L.R. 2-68 (4th Cir. 1990) at

2-76.

"A claimant must be totally disabled due to pneumoconiosis and any other respiratory or pulmonary disease, **not due to other non-respiratory or non-pulmonary ailments, in order to qualify for benefits**." *Beatty v. Danri Corp. & Triangle Enterprises*, 16 B.L.R. 1-11 (1991) aff'd 49 F.3d 993 (3rd Cir. 1995)(emphasis added). Non-respiratory or non-pulmonary conditions are irrelevant to the determination of whether there is a total respiratory or pulmonary disability. *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994).

If the claimant would have been disabled to the same degree and by the same time in his life had he never been a miner, then benefits cannot be awarded. *Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Pickands Mather & Co.*, 914 F.2d 35, 38 (4th Cir. 1990).

Only Dr. Rasmussen attributed Mr. Greene's total disability, in any part, to coal workers' pneumoconiosis. He concluded that Mr. Greene had at least a moderate loss of respiratory function, reflected primarily by the impairment in oxygen transfer during exercise, as shown by arterial blood gas results. He opined that the risk factors for his impairment included cigarette smoking, coal mine dust exposure and possible his pulmonary embolization. Based on these risk factors, Dr. Rasmussen concluded that coal mine dust exposure was a significant contributing factor to his disability.

Dr. Rasmussen's conclusion is insufficient to support a finding that Mr. Greene was totally disabled due to pneumoconiosis. Initially, the doctor leaps from listing the three risk factors for a respiratory insufficiency to his conclusion that coal mine dust exposure must be a significant contributing cause to such insufficiency is not well supported by the medical evidence of record. His opinions are further refuted by subsequent arterial blood gas results in which Mr. Greene did not have an impairment in oxygen transfer after exercise.

Dr. Rasmussen's conclusions regarding the diagnosis and cause of Mr. Greene's pulmonary condition are given lesser weight, as he is less qualified than Drs. Fino, Castle, Jarboe, and Zaldivar, who are Board-certified in internal medicine with a sub-specialty in pulmonary diseases and B-readers.

Dr. Castle examined the claimant on April 17, 1998, and concluded that Mr. Greene's total disability was due to obesity, obstructive sleep apnea syndrom, hypertension, probable coronary artery disease, previous pulmonary emboli, and age. He found these conditions to be unrelated to Mr. Greene's prior coal mine employment. Dr. Castle's opinions are further bolstered by those of Drs. Fino, Zaldivar and Jarboe, all Board-certified pulmonologist specialists who attributed Mr. Greene's disability to the same conditions as did Dr. Castle.

Dr. Daniel, who examined Mr. Greene in 1986, and submitted a subsequent report based on additional medical records in 1999, also noted that Mr. Greene developed a pulmonary impairment as of April 1998, however it was due to excess obesity, multiple pulmonary embolic, cardiac problems and age. He found the impairment was unrelated to pneumoconiosis or exposure to coal dust. (DX 31, EX 14)

While Mr. Greene was awarded disability benefits from West Virginia Workers' Compensation Fund, on January 17, 1985, based on findings by the Occupational Pneumoconiosis Board that he suffered occupational pneumoconiosis with fifteen percent (15%) pulmonary functional impairment attributable to the disease, such state agency determination is not binding on a judge. *Stanley v. Eastern Associated Coal Corp.*, 6 B.L.R. 1-1157 (1984). There is no medical evidence in the record upon which this determination was based.

G. Attorney fees

The award of attorney's fees, under the Act, is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for the representation services rendered to him in pursuit of the claim.

VI. CONCLUSIONS

In conclusion, while the evidence establishes that Mr. Greene was totally disabled from performing his last coal mine employment prior to his death, thereby establishing a material change in conditions since his prior claim, there is insufficient evidence upon which to grant his claim for benefits. The evidence presented does not establish the existence of coal workers' pneumoconiosis arising from his coal mine employment, nor does it establish that Mr. Greene was totally disabled due to pneumoconiosis or any other condition arising out of his coal mine employment. As such, his claim must be denied.

ORDER

IT IS ORDERED THAT the claim of Merlin Huey Greene for benefits under the Black Lung Benefits Act is hereby DENIED.

RICHARD A. MORGAN
Administrative Law Judge

RAM:KM:dmr

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits review Board within 30 days from the date of this Order by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601**. A copy of a Notice of Appeal must also be

served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, at the Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

APPENDIX A

Exh. #	Dates 1. x-ray 2. read	Physician	Qualific-ations	Quality	Classif-ication	Interpretation or Impression
DX 31	9/8/86 9/8/86	Daniel	U/K	+	1/1	
DX 31	9/17/86 11/8/86	Gaziano	B	1	0/1	
EX 3	4/19/96 3/8/99	Wiot	B;BCR	2		No changes consistent with pneumoconiosis. Right upper lobe infiltrate. Not CWP.
EX 3	4/19/96 3/19/99	Spitz	B;BCR	1		No evidence of CWP.
EX 7	4/19/96 5/11/99	Meyer	B;BCR	2		No evidence of CWP. Left upper lobe infiltrate. Aneurysmal aorta.
EX 16	4/19/96 3/2/2000	Fino	B;BCP	1		No abnormalities consistent with an occupational pneumoconiosis.
EX 3	4/24/96 3/8/99	Wiot	B;BCR	2		No changes consistent with pneumoconiosis.
EX 3	4/24/96 3/18/99	Spitz	B;BCR	1		No evidence of CWP.
EX 7	4/24/96 5/11/99	Meyer	B;BCR	2		No evidence of CWP. Focal infiltrate improved. Aneurysmal aorta.
EX 16	4/24/96 3/2/00	Fino	B;BCP	1		No changes consistent with a coal mine dust associated occupational lung disease.
DX 18	4/17/98 4/21/98	Patel	B;BCR	2	1/1	Simple pneumoconiosis
DX 15	4/17/98 5/19/98	Cole	B;BCR	U/R		
DX 16	4/17/98 6/12/98	McFarland	B;BCR	1	0/1	

Exh. #	Dates 1. x-ray 2. read	Physician	Qualific-ations	Quality	Classif-ication	Interpretation or Impression
DX 17	4/17/98 6/19/98	Illegible	U/K	U/R		
EX 1	4/17/98 12/08/98	Wiot	B;BCR	3		No evidence of pneumoconiosis. Low volume lungs. Subpleural fat due to obesity
EX 1	4/17/98 12/9/98	Spitz	B;BCR	2		No pneumoconiosis. Subpleural fat. Borderline heart size. Nodule in right upper lobe.
DX 21	6/29/98 6/30/98	Patel	B;BCR	1	1/1	Simple pneumoconiosis Borderline cardiomegaly. Mediastinal mass.
DX 19	6/29/98 8/17/98	Illegible	U/K	1	0/1	Abnormalities consistent with pneumoconiosis. Cardiomegaly. Asbestos exposure?
DX 20	6/29/98 8/26/98	Gaziano	B	1	1/0	
EX 1	6/29/98 12/08/98	Wiot	B;BCR	2		No evidence of pneumoconiosis. Low volume lungs. Subpleural fat due to obesity.
EX 1	6/29/98 12/09/98	Spitz	B;BCR	1		No pneumoconiosis. Subpleural fat. Borderline heart size. Nodule in right upper lobe.
CX 1	1/13/99 2/29/99	Aycoth	B;BCR	1	2/1	Complicated pneumoconiosis, category A, p/p. Suspect right suprahilar neoplasm.
CX 2	1/13/99 3/6/99	Cappiello	B;BCR	2	2/1	Pneumoconiosis. Right suprahilar or hilar neoplasm cannot be excluded.

Exh. #	Dates 1. x-ray 2. read	Physician	Qualific-ations	Quality	Classif-ication	Interpretation or Impression
EX 2	1/13/99 4/12/99	Castle	B;BCP	2		No changes consistent with pneumoconiosis. Partial atelactasis right upper lung.
EX 4	1/13/99 4/29/99	Wiot	B;BCR	1		No evidence of CWP. Findings raise question of malignancy.
EX 9	1/13/99 6/16/99	Shipley	B;BCR	2		No evidence of CWP. Partial right upper lobe collapse w/ associated hilar & mediastinal enlargement; suspicious for malignancy.
EX 11	3/9/99 10/6/99	Wheeler	B;BCR	1		No evidence of silicosis or CWP.
EX 11	3/9/99 10/11/99	Scott	B;BCR	1		No abnormalities consistent with pneumoconiosis.
EX 15	3/9/99 11/4/99	Fino	B;BCP	1	0/0	
EX 11	4/20/99 10/6/99	Wheeler	B;BCR	1		No evidence of silicosis or CWP.
EX 11	4/20/99 10/11/99	Scott	B;BCR	1		No evidence of silicosis or CWP.
EX 15	4/20/99 11/4/99	Fino	B;BCP	1	0/0	
EX 11	5/11/99 10/6/99	Wheeler	B;BCR	1		No evidence of silicosis or CWP.
EX 11	5/11/99 10/11/99	Scott	B;BCR	1		No evidence of silicosis or CWP.
EX 15	5/11/99 11/4/99	Fino	B;BCP	1	0/0	
EX 16	8/23/99 3/2/00	Fino	B;BCP	1		No changes consistent with a coal mine dust associated occupational lung disease.
EX 17	10/21/99 2/21/00	Wiot	B;BCR	1		No evidence of CWP. Within normal limits.

Exh. #	Dates 1. x-ray 2. read	Physician	Qualific-ations	Quality	Classif-ication	Interpretation or Impression
EX 18	10/21/99 3/6/00	Meyer	B;BCR			No evidence of CWP.
EX 20	10/21/99 3/25/00	Spitz	B;BCR	1		No evidence of CWP. Lungs clear.
EX 22	10/21/99 5/16/00	Fino	B;BCP	1	0/0	No abnormalities consistent with pneumoconiosis.
EX 17	11/19/99 2/21/00	Wiot	B;BCR	1		No evidence of CWP. Mass anteriorly just above right hilum; rule out carcinoma.
EX 18	11/19/99 3/6/00	Meyer	B;BCR			2 cm nodular opacity in anterior segment of right upper lobe. No evidence of CWP.
EX 20	11/19/99 3/25/00	Spitz	B;BCR	1		No evidence of CWP. Irregular nodular density in anterior portion of lung, probably right side.
EX 22	11/19/99 5/16/00	Fino	B;BCP	1	0/0	No abnormalities consistent with pneumoconiosis.
EX 17	1/17/00 2/21/00	Wiot	B;BCR	2		No evidence of CWP. Right pleural effusion. Changes in mid portion of entire right lung consistent with post-radiation change.
EX 18	1/17/00 3/6/00	Meyer	B;BCR			Ill-defined air space opacity in right para-mediastinal distribution, radiation changes. No CWP.
EX 20	1/17/00 3/25/00	Spitz	B;BCR	2		No evidence of CWP. Infiltrate in right lung medially. Right pleural effusion.
EX 22	1/17/00 5/16/00	Fino	B;BCP	1		No abnormalities consistent with pneumoconiosis.

Shaded areas indicate x-rays taken and/or read prior to the present claim.

* A- A-reader; B- B-reader; BCR- Board-Certified Radiologist; BCP-Board-Certified Pulmonologist; U/R - Unreadable film. Readers who are board certified radiologists and/ or B readers are classified as the most qualified.

** The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category 0, including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp.*, 6 B.L.R. 1-307 (1983). If no categories are chosen, in box 2B(c) of the x-ray form, then the x-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.